HIT Standards Committee
Clinical Operations Workgroup
Transcript
January 10, 2012

MacKenzie Robertson – Office of the National Coordinator
Thank you. Good afternoon, everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Standards Committee's Clinical Operations Workgroup. Excuse me. This is a public call, and there is time for public comment in the agenda, and the call is also being recorded, so please make sure you identify yourself when speaking. I'll now take the roll call. Jamie Ferguson?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Present.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Jamie. John Halamka?

John Halamka – Harvard Medical School
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, John. Donald Bechtel? Chris Chute? Martin Harris? Stan Huff? Kevin Hutchinson? Liz Johnson? John Klimek? Rebecca Kush? Marjorie Rallins? Wes Rishel? Cris Ross? Joyce Sensmeier?

Joyce Sensmeier – HIMMS
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Joyce. Dan Vreeman?

Dan Vreeman – Regenstrief Institute
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Dan. Jay Crowley? Marjorie Greenberg?

Jay Crowley – U.S. Food & Drug Administration
Here. Jay's here.

MacKenzie Robertson – Office of the National Coordinator
Oh, Jay. Great. Got you. Marjorie Greenberg? Clem McDonald?

Clem McDonald – National Library of Medicine
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Clem. Nancy Orvis? Terrie Reed? Karen Trudel? And are there any ONC staff members on the line?

Farrah Darbouze – Office of the National Coordinator
Hi. This is Farrah Darbouze from the Office of Science and Technology in ONC.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Farrah. Okay. With that, I'll turn the agenda back to you, Jamie.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Thank you very much, MacKenzie. And so today we are here to review and make comments on items we were assigned by the, by ONC for comment on the request for comments on meaningful use three, Stage 3, the standards related to potential objectives and measures in meaningful use three as outlined by the policy committee.

And so we have a draft, and I – so this is my own draft. It's not a committee work product. It's just a starting point for discussion, and so I think the – I've indicated some preliminary draft comments here for most of the items that were assigned to the clinical operations workgroup in the – in the SGRPs, not for the latter section of the document. And so what I'm going to propose we do on this call today is start with that as a first draft, and feel free to redline, edit, replace, or delete anything that I've put into this first initial draft. It's really just intended to be a starting point for discussion.

And so what I'm going to also suggest is that we go through the spreadsheet document – I guess it's a Word document that – but that we go through it, and that we first look only at the SGRPs that were assigned to the clinical operations workgroup, and then we consider anything else after we – after we do that. Does that plan sound acceptable to everybody?

Clem McDonald – National Library of Medicine
It sounds good.

John Halamka – Harvard Medical School
Yep. Sounds good.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Great. Then let me ask if the – if we could page through – now on my screen, the page is being – it's a legal-sized page that's being cut off to a letter size, and I don't know if it's possible to change the – I guess we just have to go through it this way so that we're looking at the – there's a right hand column. Is that readable to everybody on the screen? Or does everybody have a copy of this from the separate email?

Clem McDonald – National Library of Medicine
Yeah. If you name the number each time, we can –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So we're – so the first one that's being shown now is actually SGRP101. Now this actually was not assigned to the workgroup. I did put in a proposed comment here. So let's skip this, and let's go first –

Clem McDonald – National Library of Medicine
That was an easy one. I think I like that.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

John Halamka – Harvard Medical School
Yeah. I think you get my consensus, too. I know it isn't assigned to us specifically, but the idea that an externally vetted list, don't know what that means, don't know how the knowledge would be represented, don't know how it would be imported, seems a bit odd.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Okay. All right. Well, then, we can leave that – let that stand. What I'm going to suggest is let's go to SGRP103, which is I think the first one on the list that was assigned to us, which is about formularies. So the question is about formulary standards. Now I did talk to the [audio glitch] at NCPDP who assured me that their formulary standard for transmission of formularies is well-developed, is currently implemented, and is in – is stable and in relatively widespread use as version 3, which I've listed here in the comments.

I think there are two other comments I want to make. So whether we recommend version 3 or version 4, which doesn't have ANSI approval yet, is a question. I think the standard for transmission of formulary seems to be well-established. There was – I'll say previously there was a technical issue in that some of the formularies that payers wanted to trans, be able to transmit, had a variety of different hierarchy fragments that couldn't be represented in the standard, and I believe that has been fixed. So this seems to be a workable version of the – of the standard.

But as you – as I said in the draft comment here, the measure allows for generic substitution, but obviously, if there has to be adherence to a rigid formulary standard, then it doesn't allow for substitution. And so that could be a problem with adoption of the standard.

And then of course the other problem is that enabling the standard in the EHR is just fine, but how are you going to get payers to actually transmit the formulary?

Clem McDonald – National Library of Medicine
I think you're – that's a big problem, and Marc Overhage tried to do interesting things with the zillions of formularies, and I think it works fine if you're one institution that has a formulary. I don't know how you're going to do it in practice with what we have now.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So I wonder if – well, in the first place, is the – is the draft comment okay for the part that it addresses?

John Halamka – Harvard Medical School
Right. So Jamie, what happens at Beth Israel Deaconess is we get multiple formulary feeds, typically in various formats and various, you know, quote and comma-delimited files from multiple payers. We import them into our EHR. We then display tier one, tier two, tier three formulary information-based on patient insurance status, and then give the clinician the latitude to select whatever they want. So, I mean, the – I think what you've said is exactly right, which is, you know, it would be nice if instead of getting all these quote and comma-delimited files, that there was in fact a standard knowledge representation of what a formulary is that came from our various payers and PBMs.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yes.

John Halamka – Harvard Medical School
And once it's in there, maybe, again, the criteria is the EHR displays such information, but if the generic substitution is desired by the physician, then that's fine.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Okay. So –

Clem McDonald – National Library of Medicine
I think the drug – the drugstores often adjudicate that anyway, don't they? I mean, they're –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
That's true.

Clem McDonald – National Library of Medicine
– not going to change to a different drug, but –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
No, I think that's exactly right.

Clem McDonald – National Library of Medicine
It could just be a lot more complex –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So is this – is this draft comment okay as it stands, then? Are there any suggested changes to it?

Clem McDonald – National Library of Medicine
What did you say on your comment?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So the – so Clem, do you have access to the screen or a copy of the comment draft document?

Clem McDonald – National Library of Medicine
Well, I have a document. Is it the last column that has comments in it?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yes.

Clem McDonald – National Library of Medicine
Oh, okay. I do – so I'll just get that in front of me.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So yeah, so we're on 103. So what it says is basically the NCPDP formulary standard version 3 plus the editorial corrections could be recommended, or perhaps version 4, which is passed by NCPDP, but not yet by ANSI. But that flexibility for generic substitution is needed, and that argues against strict adherence to any rigid formulary standard.

Clem McDonald – National Library of Medicine
Yeah. Yeah, I like that.

John Halamka – Harvard Medical School
Yep. You got my vote.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Then let's go on to 104, SRGP104, and so this is about retiring the requirement for recording demographics. And I think the logic here is that, you know, there's a very high degree of compliance with demographic recording, and so perhaps it's not required as a meaningful use measure anymore. My draft comment says that we would disagree with that because although a high level of information recording has been achieved, if we – this is absolutely critical information, and if it's not required, then it might no longer be recorded. I've also proposed that sensitive data such as sexual orientation and disability status, which were proposed to be added, should be omitted.

Clem McDonald – National Library of Medicine
I agree with both those. My argument is a little bit different. If every time people do well you take it off the list of things they get credit for, we're going to be screwed in the long run.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yep.

John Halamka – Harvard Medical School
Yeah. And so Jamie, I certainly searched high and low, as you have, for things like gender identity standards, sexual orientation standards, and haven't found anything.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Right.

John Halamka – Harvard Medical School
Haven't found good disability status. And so I think it's both premature to suggest that those are required, and it does add a very interesting layer of complexity into role-based access control over who could see such fields, as you declare data that an individual has never publicly declared and does not want known.

Clem McDonald – National Library of Medicine
Well, and that, and doing it in a public check-in counter, you know, a lot – it'd be nice to steer clear of that.

John Halamka – Harvard Medical School
Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So I – so I think that's approval of the draft comment –

John Halamka – Harvard Medical School
Yep.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
– on 104. Now the next ones that are assigned to us, SGRP105, 106, and 107, really are – I think we can consider these as a set, because this has to do with essentially how prescriptive the requirements are for a variety of items here. And so what I said in the draft is really for – sort of for all three of these, is that best practice advisories, alternative recommendations, and health maintenance alerts should be helpful tools, but should not be mandated. And also, that in reviewing – in basically reconciling problems lists, med lists, and allergies, that patient input could be useful, but that it introduces new issues in terms of data integrity and data validity that would need to be addressed.

And so – so anyway, so that's the draft comment, and let me ask for input from the group here.

John Halamka – Harvard Medical School
Yeah, so Jamie, I certainly think of the informatics research I've done that tries to come up with smart problem lists and smart medication lists, and these things are suggestions, like, oh, they've had a hemoglobin 1C ordered every month for the last three years, but they're not a diabetic. You might want to think about that. But it's more of advice. I mean, it isn't something that we actually compute on the data and actually insert into the record. And so I think your idea of, you know, certainly wonderful to provide such guidance and advice, and, you know, we even do show the PHR, patient provided data, but it's in a different window, and it's advisory to the doctor.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. And I think that a slightly broader issue that I added only in 106, as an example, with the external data on fill status of medication orders, is – but it's really – it's the broader question of validation and integrity and validity of externally sourced data. And so I just think that the reliability of those data is not really known. There aren't well-established processes for validation and so forth. And so I think in my view it's absolutely premature to even consider mandating anything, any – you know, whether it's getting a fill status notification that would actually go back into the patient record from the – from the – a remote pharmacy, or whether it's patient-supplied data about problems, meds, and allergies, it's nice information to have, but using standards in a uniform and rigid way to update things that would generate decision support is just not an operational reality that we can see.

Joyce Sensmeier – HIMMS
Jamie, this is Joyce. I agree with you. I just hope that we can point to the future on this, and I think you have captured that in your comments, where it's not like we're disregarding patient input as a consideration at some point. We're not there yet. But to really get the – plant the seeds for that as something that we want to get to is I think a really good thing that we can –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah, so what I tried to say was that, you know, patient input could be used, but it raises new issues.

Joyce Sensmeier – HIMMS
Right.

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And we haven't resolved those issues.

Joyce Sensmeier – HIMMS
Yes.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So we – you know –

Joyce Sensmeier – HIMMS
Right. So it goes even farther than making it a marker. You identify the things that we need to consider before we get there. I like that. Just a minor typo on issues. You probably saw that.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Oh, yeah. Yep. Yep. Okay.

Clem McDonald – National Library of Medicine
Well, this is – all these are really also described as sort of reconciliation issues, and it's not just the external – I mean, these are tough problems, because the problem that we – problem list has always had problems with usage, because people attach text and things to a given problem, and then they mature, it goes from chest pain to heart attack to arthroscopic heart disease. And this is all – and there's multiple problems by different people. So it's really, really tricky.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. I mean, you know, even for us, updating severity and progression is one of the things that we've struggled with.

Clem McDonald – National Library of Medicine
I would – I think these are just huge burdens that we don't know how to do yet, and we're doing with a system at a level that's not going to be useful for the system. So I would – I would even say stronger negatives on these things, not that people shouldn't look at other stuff and listen to the patient. There's no intention to say that. But, you know, you got your list, and you work with what you – what you can see and hear, and fix it.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So one way to do that, Clem, would be to add a – an initial statement on each one of these that we recommend against standardizing this at this time.

Clem McDonald – National Library of Medicine
Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And then leave the rest of the comment. How do folks feel about that kind of an approach?

Clem McDonald – National Library of Medicine
Good.

John Halamka – Harvard Medical School
Fine with me.

Joyce Sensmeier – HIMMS
Yeah, me too.

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Let me just take some notes here. Okay. All right. Good. So now we're on to SGRP108, and so this is about recording and charting changes in vital signs. The recommendation – or the proposal is to retire the measure. Now in this case, I agree that this could be retired, and how do others feel?

Clem McDonald – National Library of Medicine
Well, what's going to happen if we only retire the ones they succeed with? I mean, something seems wrong about that. Is that me?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, I think, you know, so part of it is that – the question is what's the greatest total number of measures that there should be? And in every stage of meaningful use, there's a desire to add more, but do you just add more ad infinitum, or do you say that, you know, we've achieved sort of the maximum level of the number of measures that can reasonably be managed in operations, and so if you want to add something, you have to take something away?

Clem McDonald – National Library of Medicine
Well, it depends a little on how these are ultimately going to be used; that is, reports on doctors' performance. You know, we're going to have always a downhill slide if, you know, as soon as you get over one hurdle they raise it another foot. So I don't know whether it's – I don't know – it's the bigger picture that I don't understand well enough. I could see that you wouldn't want to have people taking only the easy ones, but why couldn't they still report on the ones, and just add – I don't know. Could someone else help me with that?

John Halamka – Harvard Medical School
I mean, this is an interesting challenge, which is imagine today's EHRs pretty much, you know, everyone who's ever done an EHR records the insurance of the patient that is necessary for billing, right? We've been doing that for 30 years. So to have a criteria that says, did you record the insurance of the patient, well, it's sort of silly. Everyone's done it for so many years, it's immaterial. Is there a point at which some of these criteria are so ubiquitously adopted by everyone that, you know, everyone's just going to say, of course we do it?

Joyce Sensmeier – HIMMS
Yeah. It's almost like – this is Joyce Sensmeier. Almost like charting by exception, where it's assumed that you do those things, but it's not that we want to forget them or certainly eliminate them. But is there a way to say they're assumed, or the idea of charting by exception?

Clem McDonald – National Library of Medicine
Well, the blood pressure is just as important as their ethnicity for an awful lot of health issues, so I can see your points, but just the theory that what we're always going to do is take out the ones that they've achieved and always find some ones they haven't is worrisome.

Joyce Sensmeier – HIMMS
Yes. I –

John Halamka – Harvard Medical School
And I think Jamie has tried to be balance in this. He said, you know, there are some that are just so incredibly important that we don't want to take out, and others that are so ubiquitously adopted that it's probably fair. So, I mean, I agree, Clem, with your sentiment. The last thing we want to do is say, you just worked to run a marathon; here's another.

[Laughter]

John Halamka – Harvard Medical School
Give people some credit where those – where credit – you know, it should be balanced.

Clem McDonald – National Library of Medicine
Mm-hmm.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, so for 108, 108 is vitals, 109 is smoking status, and so the proposal is to retire both of those. In the draft, I've agreed with retiring both of those. What's the sense of the group?

John Halamka – Harvard Medical School
Well, what's interesting is it isn't exactly retiring them, because they're still retired for the quality measures.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
That's true.

John Halamka – Harvard Medical School
So, you know, in some sense it's less you have to report on in your attestation, but the measures still need to be recorded.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
That's true. It's not – it's not that you don't need it for other purposes.

John Halamka – Harvard Medical School
Yes.

Clem McDonald – National Library of Medicine
On the – to the point on the smoking history, I think that's actually – as it's conceived, is not going to be very useful – is not going to be sufficient. Right? Isn't it just some sort of –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, yeah. And there's actually a separate proposal I think to have a finer-grained definition of smoking status.

Clem McDonald – National Library of Medicine
Well, I mean, if you're going to really try to see what people are – where they're getting with smoking, I think we need, you know, packs per day and things like that somewhere along the – but that could be later.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, yeah. And as John said, that comes out in the – in the quality measure, where I think the proposal is to have a finer-grained definition of a different taxonomy of smoking status and smoking history.

Clem McDonald – National Library of Medicine
And then you might want to retire this so you don't have to do both.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So do we have agreement to retire – to recommend retiring both 108 and 109, then? Is that okay?

John Halamka – Harvard Medical School
Fine with me.

Clem McDonald – National Library of Medicine
Yeah, but if you could somewhere put as an overarching discussion, how are people going to be scored over time, when thinking about the retirement of stuff they're successful at.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Let – Clem, let me ask you to bring that up again at the – towards the end of the call, after we go through the detailed items. Is that okay?

Clem McDonald – National Library of Medicine
Sure. I don't even know how to do it, but –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. All right. Okay. Good. Now SGRP112 is an item that was not assigned to us, but I just made a comment briefly agreeing with the need to ensure standards support for whether patients have advanced directives or not, but not saying how to do it.

Clem McDonald – National Library of Medicine
Yes. And I think that whole thing is a good – a good direction.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
SGRP113 is the next one that was assigned to us, and this is really one that I think I've heard many of us say we would want to push back against. And so the proposal is for EHRs to consume CDS interventions, decision support interventions, from the central repository of decision support rules, so that the EHR would query available databases to identify trigger event conditions based on patient's health condition, diagnoses, location, and other facts. And this to me I have to say doesn't seem anywhere close to an operational reality that could be standardized. There are no central repositories that are agreed upon for these rules. There is basically – the standards for transmitting the rules and the data that the rules feed on are both highly immature, and the ability to current EHRs to produce structured, coded data that could be used for that purpose is also really immature.

So in the draft I've recommended deferring or reconsidering this objective and standards for it.

Clem McDonald – National Library of Medicine
Can I just – to orient, you're on which?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
One thirteen.

Clem McDonald – National Library of Medicine
And it's got two cate – it's got two sections, right? At least you have – you have responses in two sections.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
The responses – yeah. The second section is not assigned to us. That's the question on payer experience.

Clem McDonald – National Library of Medicine
Okay. All right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
The first section is the part that I just read. And so the draft response says we should defer or reconsider this. Central repositories don't exist. Standards are immature. And more tracking, flagging, and alerts may make decision support more detrimental than useful. We would recommend a more flexible acceptance of tools that are adaptable to different practice patterns, and that allow for established clinical workflows to exist.

Clem McDonald – National Library of Medicine
Hear, hear, and there's no way on earth that we're going to get a central authority that's going to get it right. It's going to be some really horrible overkill.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
You know, I'm not trying to say that decision support is bad, and we have – in Kaiser, we have a lot of work going on with other organizations on rule representation that may lead to the potential for sharing rule repositories and things like that, but this is years and years in the future.

Clem McDonald – National Library of Medicine
I agree.

John Halamka – Harvard Medical School
And so Jamie, what I had suggested at the beginning of the call is I'm keeping a laundry list of the work plan for the standards committee over the next year and after, and so I absolutely agree that CDS knowledge representation and APIs to query CDS are very important things that the standards committee should discuss. They just don't belong in Meaningful Use Stage 3.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
They don't belong in Stage 3, nor, in my view, should they even be on a 2013 work plan. It's really premature.

Clem McDonald – National Library of Medicine
Hear, hear.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I mean, well, let me say that they could be on a multi-year work plan.

Clem McDonald – National Library of Medicine
Right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
But this is some – this is something that we shouldn't have – you know, we shouldn't try to get a date say within the next year by which we will have resolved these problems. That's just not realistic.

John Halamka – Harvard Medical School
Right. Yeah. And concur.

Clem McDonald – National Library of Medicine
But Jamie, there's this thing about prior authorization. Is that – is that for us?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So I think the prior authorization is actually the – more related to the payer question for the implementation workgroup, but is there something we want to say about that from the –

Clem McDonald – National Library of Medicine
I think we should, because there's two parts to it. One of them is being able to do that online, is probably reasonable, especially if one could pull up whoever is asking for it, what they want. But having physicians have to do it I think is horrible. And I think somewhere else it suggests that.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, but I think also just the notion of putting prior authorization – so I would push back against that even further, because the notion of the – of prior authorization is tied to some specific fee for service payment models and modalities that frankly are at odds with the development of accountable care, risk sharing. It's frankly completely irrelevant for capitated organizations like mine. And so this has absolutely no place in meaningful, from my perspective.

Clem McDonald – National Library of Medicine
Well, if you keep it off the physician's docket, I'm for it.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So I don't know how others feel about that sentiment, which I did not put in here. But –

Clem McDonald – National Library of Medicine
Well, there's – there is – I know from the attachment workgroup at HL7, there's a lot of interest in capturing that stuff more easily, and with less paper moving around. So it – I think in the long run it may mean – well, there's a lot of issues. Once they get at the physician's desk, they've got to add 50 more questions to it, too. So that's – the idea of doing a more systematic, easier to gather data when it is required by somebody, isn't awful, but making it be a physician's task –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, let me ask Joyce and John, how do you feel about that?

John Halamka – Harvard Medical School
Right. So again, my – for the whole CDS topic, the idea that it is premature and that we on a multi-year work plan will, you know, certainly more forward with it, is the sentiment I would like to convey.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Joyce Sensmeier – HIMMS
Yep. I –

Clem McDonald – National Library of Medicine
Well, I wouldn't be that positive. I'm more on Jamie's side, or that – in terms of moving –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So no, so I think I would say that putting this on a multi-year work plan is appropriate for sort of basic research and standards development work.

Joyce Sensmeier – HIMMS
Right.

Clem McDonald – National Library of Medicine
Let me see. One second. Now there's a lot of other detail – oh, this is all part – you know, about maximum dose. Are we responding to that? There's a lot in this – in this proposal. Or just –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, I've tried to capture that just by saying that in all those areas, more tracking, flagging, and alerts may be more detrimental than useful.

Clem McDonald – National Library of Medicine
And I agree with that 100 percent, too.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Do we need to be more specific about that?

Clem McDonald – National Library of Medicine
Well, I just want to read through the list and make sure that we're covering this. Certification, track CDS – tracking of CDS triggers I think – is that – that is – you're not arguing for that, right?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
No.

Clem McDonald – National Library of Medicine
Oh, yeah. Okay. Well, we maybe should be a little stronger about the specific items from one to five under the certification criteria, but we don't have to do it now. Structured SIG standard is going to be tough. I mean, and trying to record sigs without just signing them in text is going to be tough. So a lot of those are going to be hard on physicians. They're not strictly decision support. That's all I have to say.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So let me add a statement that in all of the different – in all of the certification criteria proposed areas, this should be deferred and – or reconsidered. Is that okay?

Clem McDonald – National Library of Medicine
Mm-hmm.

John Halamka – Harvard Medical School
It's fine with me.

Joyce Sensmeier – HIMMS
Mm-hmm.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Just a sec. Okay. All right. Good. Anything else on 113? Joyce?

Joyce Sensmeier – HIMMS
I'm sorry. No, it's not specific to this, but if we could, whoever's displaying the screen could scroll it a little bit more to the left. So the right hand side is dropping off. Oh, the other way. Sorry. The opposite way. I want to make sure I'm seeing all of the comments, and it was – there, exactly.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Okay. Good. Thank you.

Clem McDonald – National Library of Medicine
Those who have printers, this can be fit on a 8.5 by 11 pages, and it just came out printed that way, if you want another way to look at it.

Joyce Sensmeier – HIMMS
Oh, thank you, Clem. That's brilliant. Thank you.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Clem McDonald – National Library of Medicine
I don't know how much work my assistant had to do to do that, but it'll fit.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So now we're on to SGRP114, which is about increasing the threshold for incorporating test results, lab test results, into the EHR as structured data, and so that was not specifically assigned to us, but I've suggested that we reply that the increased threshold should be workable.

Clem McDonald – National Library of Medicine
Yeah, I – and I'd ask why in the world are we so timid?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
You know, an HL7 message that sends a yes/no can send a narrative text just as easily, and this idea of restricting it to those things that are ordered by computer is going to cut out may half the tests from people who are already getting them electronically.

John Halamka – Harvard Medical School
Oh, and Clem, it turns out that our friends at ONC issued an NPRM redacting that component of the requirements, so that it in fact would be results that would be sent in electronic form, regardless of how they are ordered.

Clem McDonald – National Library of Medicine
I think that – the way I read that, the redaction was that they could do that, too, but it wasn't pushed.

John Halamka – Harvard Medical School
Yeah. Because we get faxes, we get paper order sheets from the outside. I mean, although everyone inside is electronic, you know, who knows what the outside world's going to do.

Clem McDonald – National Library of Medicine
Well, I mean, we might just want to see – or at least probe the idea of strengthening it, that any results that they send electronically, regardless of how they came in, they would send them in structured form, which means they'd be file-able at the other end.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So I don't – I don't disagree, but I think that's outside the scope of our comments here.

Clem McDonald – National Library of Medicine
Okay.

John Halamka – Harvard Medical School
But there may be – I think there was somewhere later in the document about electronic ordering of labs.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Clem McDonald – National Library of Medicine
Yeah, and that's okay. I – it's just that there are other barriers to electronic ordering that aren't – a lot of results are getting sent that aren't entered by doctors or electronically.

John Halamka – Harvard Medical School
Yeah. So a just sort of interesting work plan issue, Clem, since you're the expert here, would you agree that the standards committee probably still has additional work on compendia and vocabularies to ensure that electronic lab ordering is standardized?

Clem McDonald – National Library of Medicine
Yes. In fact, I think there's efforts going on. I just talked with Dieterle, who's part of the ONC team, or at least he's a consultant to the ONC team, so there is work going on, and yes, yes.

John Halamka – Harvard Medical School
Good.

Clem McDonald – National Library of Medicine
And – well, this is not apropos to this column at all, but, you know, EKGs are real easy. I think 80 percent come from one company, and they have – they can send them at standard HL7 message with codes in them. I just think we're so timid on the getting results in.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Well, let's move on. So on 114, I think that draft comment can stand, then.

John Halamka – Harvard Medical School
Yep.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
One fifteen, another one not assigned to us, but I've proposed that – this is one that I think if – in order to have standards for generating lists of patients for specific conditions, some of the things that are mentioned here would have to be better defined to assist the standards select – the standard selection. And I think that does have a clinical operations impact.

Clem McDonald – National Library of Medicine
And a lot of these things, I think they really should first describe some scenarios more clearly about how it might be and should be used and how it would be useful, because most systems will have these kind of things without requiring them by stan – by regulation.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

John Halamka – Harvard Medical School
So I agree with your comment, Jamie.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Thank you. Moving on, then, to the next one assigned to us, which is SGRP118, now this is asking for us to consider what barriers could be encountered in moving into core imaging results being accessible through the certified EHR technology. And I'm not sure how to respond to that, partly because I, you know, my sense is that my own organization may be atypical.

John Halamka – Harvard Medical School
Well, so Jamie, a couple of comments. This one is just weird in general. So EKGs are not an image.

Clem McDonald – National Library of Medicine
Oh, well, they're thinking it's a PDF.

John Halamka – Harvard Medical School
An EKG is a time series.

Clem McDonald – National Library of Medicine
I know. But they're still picturing PDF.

John Halamka – Harvard Medical School
Well, it could be a PDF. It could be actually discrete data. It could be actually done in HTML5, right? It's not DICOM. No one represents an EKG in DICOM. And so what you wonder, Jamie, I mean, when I think of images, the important issue to me is that images should be able to be exchanged across the community using a set of standards, and that as we think of HIE goals, let's include images. But the ability of an EHR to natively retrieve the images, I mean, ours has a single sign-on patient context specific URL to the GE PAC system that enables you to just click inside a report and see an image, but it just seems a bit weird to include –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. And it – and of course, it's dependent on having the appropriate image repository management, which is in fact the big deal.

John Halamka – Harvard Medical School
That's right. And so we have a vendor neutral archive, and it has nothing to do with EHR at all.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. So I like what you said, John, and so perhaps we could recommend from this workgroup that this objective should be reframed as a community-wide sharing of images using standards-based mechanisms as a – as a future HIE objective, but also not for MU3, in my view.

John Halamka – Harvard Medical School
Right. And also, strike EKGs as an image.

Clem McDonald – National Library of Medicine
Well, let me push back a little bit. I mean, I like this because it's – at least it's trying to give something to the clinicians, and I – I'm not disagreeing with anything you said. And EKGs are actually quite easy to send in a couple of forms. There's – it used to be one vendor, and I think GE bought them, but you could push the button and you could get HL7 version 2, you could get a PDF with the version 2, you could get any of those things. And that's doable today, very doable today. So any place we can get more data into the clinician's computer, I like. I don't know how you could soften it so that it would be – you know, trying to do the whole community gets into all the political things, which would put it off for five years, probably. So I would say agree with reframing it, but maybe narrowing so there's doable tasks, and clarifying that an EKG is not strictly an image. But I think EKGs would be nice to get. You know, you need them –

John Halamka – Harvard Medical School
Oh, yeah. Yeah. No, I don't deny that the notion of I should be able to retrieve an EKG or an image from anywhere in the community through standards-based mechanisms is the spirit of what we're getting at, and that would be a win for the doctors.

Clem McDonald – National Library of Medicine
Well, if they could just send them to them and let them decide, and, I mean, granted, the image – you know, you send a whole CT, it's a bit big.

John Halamka – Harvard Medical School
Right.

Clem McDonald – National Library of Medicine
But you can actually send a chest x-ray fairly – well, let's stay out of that. But EKGs you can send easily.

John Halamka – Harvard Medical School
But so here's an example of what we did. We implemented lifeIMAGE as a product, and lifeIMAGE is done at Care Group Partners, Children's, a number of other places in Boston. And if we wish to exchange images, we have a cloud-hosted image exchange facility that enables us once we view the image, if we wish, to incorporate it into our local vendor-neutral archive or PAC system.

Clem McDonald – National Library of Medicine
All right. Well, is that something that's fairly widely available, and so it doesn't have to be five years off?

John Halamka – Harvard Medical School
I mean, it's a product. You can buy it today. It's just it's one of these things that EHRs have very little direct connection to image sharing products.

Clem McDonald – National Library of Medicine
Mm-hmm.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

John Halamka – Harvard Medical School
So I think you'll see that by the nature of ACO formation, everyone wants to reduce imaging costs, so we're highly incented to implement such products. It's just tangential to EHRs.

Clem McDonald – National Library of Medicine
Well, if we could leave something that would be a pull in the – in the response to reshape it rather than discarding it, I would like that.

John Halamka – Harvard Medical School
Right. Yeah, you –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So I think we're talking about reshaping it. So here's what I'm drafting, is that we should reframe the objective as an HIE objective to share images after MU Stage 3. We need to clarify that EKGs are not images, but could be useful to physicians. Excuse me. And that the ability to access images is not a core EHR function, but can be enabled by linked access to imaging systems.

Clem McDonald – National Library of Medicine
Well, I wouldn't go that far in defining the ifs and whats, because, you know, a lot – every patient takes that CD-ROM home with their chest x-ray and their – you know, so there's – I wouldn't constrain it to it has to be out of the EHR, but just some way that images could be made more available in practice, either through IPs or through direct delivery, and let's – and see what comes out.

John Halamka – Harvard Medical School
And we're not going to be specific as to how the HIE does it, but the fact, as Jamie said, it's – the spirit of the recommendation is data liquidity –

Clem McDonald – National Library of Medicine
Right.

John Halamka – Harvard Medical School
– for images and EKGs, and that is tangential to EHR functionality.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So I broadened that a bit as a result of this.

Clem McDonald – National Library of Medicine
Okay.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Good. Let's see. I have – there are a couple of ones coming up that were not assigned to us, but I drafted brief comments anyway. One – in 119, which is about recording high priority family history data, I just said, well, this should be a menu set objective, but not core, and that we need to define what is high priority data, not just say high priority family history data.

Clem McDonald – National Library of Medicine
I agree with that. I think, you know, this whole family history thing bugs me, because NIH had a – NIH is pushing it. Is anybody on the phone from NIH? I often say things that aren't right. But they actually had a big meeting, a big workshop, which came to the conclusion that there's no evidence yet that family history collection has any effect on healthcare outcomes. So we're basically saying we've got to do some new work that is – there's not yet proof for. So I would – now they already have it in the other – and then there's the risk that it's going to get into a whole – you know, you've got to get the whole family history profile, make the tree, which is like half hour, 45 minutes worth of work.

So I agree that we should get it defined, but I would almost like to get in there that we should have some indication of the rationale and the value proposition.

Joyce Sensmeier – HIMMS
This is Joyce. I'm certainly not opposed to getting a value proposition. I think that's a great idea. But I think, you know, this is new capability, and there is a tool that's XML-based for this that is simple to use, and I've done that with my family. So it'd be great to be able to provide some visibility to this capability and get it to move forward without … –

[Crosstalk]

Clem McDonald – National Library of Medicine
Surgeon General that you're speaking of?

Joyce Sensmeier – HIMMS
Pardon? I'm sorry, Clem. I –

Clem McDonald – National Library of Medicine
Is that the Surgeon General's –

Joyce Sensmeier – HIMMS
Yes, it is. Yes, sir, it is. Mm-hmm.

Clem McDonald – National Library of Medicine
Yeah. There's nothing wrong with it. It's just when it becomes regulatory and –

Joyce Sensmeier – HIMMS
Right.

Clem McDonald – National Library of Medicine
– you have to spend time on it, where in a particular patient it may have no relevance.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So if I've captured the com – the additional comment that the definitions need to be based on a value case analysis.

John Halamka – Harvard Medical School
Sounds good.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Then the next one is 121, and so this one has to do with providing structured lab results to eligible professionals, sending directly or indirectly to the ordering provider for more than 80 percent of the orders that are – of the electronic orders that are received. And so what I've drafted is a recommendation to continue this as a menu objective rather than a core measure, rather than a core measure, because of problems especially among community providers and smaller hospitals in the implementation. So how do folks feel about that?

Clem McDonald – National Library of Medicine
Well, again, I'm like – I'd like to get more stuff into the office practice computer. They have tremendous troubles because it isn't required by the labs. I mean, it isn't strongly required, you know, so everybody does it differently. This is for – this is for what year, now, we're really talking about? Twenty sixteen or –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, it's really for – it's for EHRs in – starting in 2015, really.

Clem McDonald – National Library of Medicine
That's three years away, and if they can't get it by then, we should all quit.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, two years away. And, you know, I mean, I think that the question is the burden on community clinic testing, you know, community clinic labs and smaller hospital labs. That's the real –

Clem McDonald – National Library of Medicine
Well, we could exempt – I'd rather exempt the smaller hospitals, under 100 beds, than not really get this done.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, it's currently – would be in there as a – as a menu set objective that could be chosen. And so the question is whether to make it core or not.

Clem McDonald – National Library of Medicine
Well, you know, the big institutions really aren't troubled by this. I think this doesn't apply for internal reporting. Or didn't, at least, in the last round. Do you think this might?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I don't know.

Clem McDonald – National Library of Medicine
I think – I think it's for providers who are outside of the organization from any institution. But the big commercial labs are going an awful lot electronically, and have done –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Oh, no. Yeah. I mean, I think the question really is about hospital labs.

Clem McDonald – National Library of Medicine
Well, they're the ones – they're half the volume, and if we don't get them going, we're not – the offices aren't going to have full records, complete records, for anything. And then electronic record isn't worth that much. I'd be for staying with this, but –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. How – do others agree with that?

Clem McDonald – National Library of Medicine
There'll be push back enough from the community if it really is going to be horrible.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So I can just remove that comment, then, and let it stand.

Clem McDonald – National Library of Medicine
Well, I'd like to hear from others. I'm talking too much.

Joyce Sensmeier – HIMMS
No, I agree, Clem.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

John Halamka – Harvard Medical School
And so, Jamie, is the suggestion that we make it go forward as core, or that you're going to leave it as menu set?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, the proposal is to make it core, and so if we don't comment, then it would just stay as core.

John Halamka – Harvard Medical School
Yeah. I mean, Clem has an interesting point, which is my community hospitals and community physicians have basically told me, unless I deliver results to them electronically, they won't do business with me anymore.

Clem McDonald – National Library of Medicine
Oh.

John Halamka – Harvard Medical School
And so it's funny, again, sort of a private HIE ____ environment, we kind of have to do this. So I certainly, you know, agree that the trend seems to be that it should be done by most academic health centers serving as reference labs, and therefore leaving it as core is reasonable.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

John Halamka – Harvard Medical School
So –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Good. The next item that was assigned to us is 204A, which has to do with exploring the readiness of vendors and pros and cons of including images, actual images, not just reports, in the ability to view online – to view, download, and transmit data. And the menu item specifies the use of the Automated Blue Button Initiative, or ABBI, specification, which, you know, I think just – so the comment that I've proposed in the draft is that we would want to allow innovative and flexible approaches, in addition to ABBI.

My color commentary on that is that – two things about the Automated Blue Button Initiative. One is it's just in pilot testing, and so it – I don't think it's well-established or well-proven. The other thing is, it's really based on very older technology, and it doesn't necessarily enable patients to be able to – it doesn't guarantee any usability of what is – what is downloaded. And so my view is that it is – really pretty strongly that we – this is an area where innovation needs to be allowed, and we don't want to tightly restrict patient downloading to this one mechanism.

John Halamka – Harvard Medical School
And so, Jamie, are you familiar with a Microsoft technology called Deep Zoom?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
No, I'm not.

John Halamka – Harvard Medical School
Okay. So it turns out that, you know, there's this sort of ubiquitous problem, sure, we have it in healthcare, but it exists in many other industries. How do I take a very, very say high resolution image that takes a lot of storage and bandwidth, but, you know, I actually only want to drill down on the upper one percent of it. And so Microsoft has created a product and has made it available in platforms like Java and Flash that allow you to take and stream large density images, and narrow down just the portion of the image you wish to see the detail of.

So to suggest that, oh, this has to be Automated Blue Button, well, why not email a URL via DIRECT of a Deep Zoom object that allows the individual to look as close or not as close to their fracture as they wish? You know, it's – I think it's – it is exactly as you say, presupposing a technology that is just embryonic should be used, when in fact Automated Blue Button may not be appropriate at all. So I like what you said.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

John Halamka – Harvard Medical School
And for fun, Jamie, I'm going to send you an x-ray DICOM object that's Deep Zoom that will allow you in any browser to do a full, beautiful, pan, zoom, adjust windows, with zero client side software.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Oh.

Clem McDonald – National Library of Medicine
Jamie, this 204A has, one, two, three, four, about five sub-comments.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
Which – or seven – no, five.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
Which one are we talking about?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And so this is just the first one now, which is on including images in the objective. The second one, which was assigned to us as a secondary item, is about radiation dosing information, so that patients can view the amount of radiation they've been exposed to. I didn't propose a comment on that.

Clem McDonald – National Library of Medicine
But there's – okay. Well –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And then – and then the other one is I think the last – the last one in this – no, the next to last – the last one and the next to last one are others that were assigned to us. And – well, I guess that's 204B. Sorry.

Clem McDonald – National Library of Medicine
Well, some of the other columns have additional detail, like reviewing patient transmitted information.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Clem McDonald – National Library of Medicine
Is that separate – I mean, that's orthogonal to sending images to the physician, I guess, right? Or to the patient? The third column. So the third column has these additional things that are different and should be commented on, I think. Providers to review patient trans – yeah, that means –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
– that they got to – they have to spend time doing that, and it says – no discussion about whether it's mutually agreed on that they're going to send that information.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Right. So you're on the last subsection of that, of –

Clem McDonald – National Library of Medicine
Oh, it is?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And – or that's the – that's on 204B.

Clem McDonald – National Library of Medicine
Okay. I'm sorry. Just parallel –

[Crosstalk]

Clem McDonald – National Library of Medicine
– images, though, I'm assuming a PDF is – I mean, mostly what I see with images, there's –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So let's – let me back up a little bit. So I think – I wanted to ask if we want to make any comment on providing radiation dosing information to patients, and then we'll get – we'll get back to ____. Is there anything on dosing information that we want to say –

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
– putting that in patient-downloaded data?

Clem McDonald – National Library of Medicine
There's two pieces to that. One, I think if it were really available, it would be a really good thing to have for both physicians and patients, but I think it's difficult currently, still, to pull that from each – from a study. John, do you know more about that?

John Halamka – Harvard Medical School
Yeah. I mean, we do it here. For every one of our images, we have what is an estimated radiation dose. I don't know whether it's in microsieverts or millirems. I don't recall. But – so that we can actually accumulate radiation dose, and when a physician goes to order a study, we display the accumulated radiation dose information, so that may impact physician behavior. But sharing it with patients? I mean, it's an interesting question, because I'm just not sure – if I told you, Clem, that you had 50,000 microsieverts this year, what would you do with that information?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
Well, you might go out drinking.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I mean, you know, when I was in the lab, of course, we all had to wear radiation film strips, right?

Joyce Sensmeier – HIMMS
Right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
You remember those?

Clem McDonald – National Library of Medicine
Well, I mean, the other thing, this requires – the first step is asking that it be put somewhere, that it can be gotten by anybody. And we have a lot of this stuff where we're at the end of the – we're at the wrong end of the cart, and the horse – I mean, if we're going to do something with this, it might be to ask that radiation doses be included as part of an x-ray report as a structured field. Then you could talk about being able to delivery – then it could get to the physician, and they could maybe deal with the patient. But right now, it's not anywhere universally, right?

John Halamka – Harvard Medical School
Yeah. And so – yeah, I certainly could imagine something like a menu set item that enables physicians to view dosing information when placing orders for radiation studies.

Clem McDonald – National Library of Medicine
Well, that, and maybe delivery of the – you know, if they are doing it increasingly, why not just store it and send it as part of the x-ray report?

John Halamka – Harvard Medical School
Yeah.

Clem McDonald – National Library of Medicine
I mean, there's issues to ask, but the first base is just put it somewhere that people can get to it, and the second step is to send it to – I mean, if they say they've got to deliver it to the patient, but it's nowhere, what good is that going to do? Or what – how could it ever be done?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So, you know, I think, Clem, you just said something really useful, which is that we could suggest adding dosing information as a requirement in radiology reports, period.

Clem McDonald – National Library of Medicine
Yeah.

Joyce Sensmeier – HIMMS
Right.

John Halamka – Harvard Medical School
I like it. And then, Jamie, just for fun, I just send you a patient visualization of radiation dosing showing the comparison between your mammogram and your 747 flight across the United States.

Joyce Sensmeier – HIMMS
Great.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I'm screwed.

[Laughter]

John Halamka – Harvard Medical School
Yeah.

Clem McDonald – National Library of Medicine
Which one is higher?

John Halamka – Harvard Medical School
Let's just say Jamie's got a glowing personality.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Well, and I used to live in Colorado, which, you know, just the natural – there's so much uranium on the surface that just living in Colorado is, you know, for a month, is equivalent to a flight across the country or something.

Clem McDonald – National Library of Medicine
Really?

John Halamka – Harvard Medical School
Right. So to give you a comparison, Clem, a flight from New York to Los Angeles is equivalent to standing on Fukushima Daiichi for an hour.

Clem McDonald – National Library of Medicine
Really?

John Halamka – Harvard Medical School
Really.

Clem McDonald – National Library of Medicine
Oh, God.

[Laughter]

Clem McDonald – National Library of Medicine
I'll start taking trains. And you get the radon, probably, from the gravel.

John Halamka – Harvard Medical School
That's it.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Okay. So now the next item, actually, the next sub-item here is the first part of SGRP204B, which talks about the readiness of standards, is questioning the readiness of standards to include medical device data from the home. And so the draft response that I've drafted here is that there – is that home device data should be deferred until after the FDA UDI final rule is published, and that then meaningful use dates for device data should be aligned with the UDI requirements for class three devices.

And so there are two thoughts behind that that I didn't enumerate here, but one is that the standards for integrating home device data and standardizing device data messaging need to mature, and that – and we – in my view, we would not want this at all without the UDI. So I think it clearly needs to be linked to unique device identification, so that you really know the source and understand the parameters for – or have the ability to understand the parameters for the – for the device that's generating such data, and give more time for the messaging standards to mature.

Clem McDonald – National Library of Medicine
Well, Jamie, I'd just qualify that the UDI is – I've just been at some UDI meetings. I don't think by itself it's going to give you the internal – you could read it in text, but it's going to give you automated information that you can then use to interpret what data you get electronically.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well –

Clem McDonald – National Library of Medicine
Just a cost –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
– you know, it's kind of – that's a – that's an interesting question. So – and Jay, I hope you're still on the call. So if it turns out, hypothetically, in the final rule, that the class three devices that we're talking about here are all marked and labeled clearly with a – with a UDI, how can we reasonably expect to get the UDI to a care provider who's receiving information from that kind of a device?

Jay Crowley – U.S. Food & Drug Administration
Jamie, this is Jay. I am still on. It will be in human readable form. Is that the question?

Clem McDonald – National Library of Medicine
Well, Jamie, I think there's two parts. One, it's easy to imagine how the device could send its own UDI, although a lot of existing devices don't send anything about their internal IDs, which they have. The question is if you've got this device, there's not going to be an automatic place to go pull an object definition and then suck in the data that it would produce as its currently evolved. That would – it would be a first step to be able to do that, if that's what you were thinking of, Jamie.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

John Halamka – Harvard Medical School
And then, Jamie, quick question. You know, as I said, I'm keeping this longitudinal list of our work plan.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

John Halamka – Harvard Medical School
Would you agree that we should put – I mean, in addition to consumer generated data issues in general, that consumer owned device data content standards and UDI would be part of our FY13 work plan?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I would put it on a multi-year work plan, personally, because I think that this is another area where even if the messaging standards for those device data matures within 2013, I don't want to get it if I don't know what device it's from, right?

Clem McDonald – National Library of Medicine
Right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And the UDI I don't think is going to require that for three more years.

John Halamka – Harvard Medical School
Got it.

Clem McDonald – National Library of Medicine
But – well, that's a longer discussion, but I was going to bring up the other issue is that there's – is that there needs to be some equivalence on both sides of the sending. If a patient just starts sending, you know, blood pressures every couple of hours to a practice, how are they going to absorb that in terms of looking – what is the expectations on the two sides? So it almost seems that there should be some mutual agreement before this stuff is being sent, or maybe that's implicit. And that someone – some expectation they're not going to be looking at it every second, or they may not be able to look at it till tomorrow, or –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
There's a couple of studies done with glucose monitoring that suggests what it actually does is increase costs, because the nurse who's looking at it, if it's a little off, they – they're going to play it safe, and they have the patient come in for a visit, but it didn't change anything in the outcomes, in a couple of studies I know about. I don't know how to put that into this issue. Having the ability is good. Having the requirement that one must accept and process it under any – without any agreement, is not as good.

Jay Crowley – U.S. Food & Drug Administration
Well, Clem, that actually – that goes to the – it is in 204A, your – the fourth column or whatever, building on automated transit. That's talking about creating the ability for providers to review patient transmitted –

Clem McDonald – National Library of Medicine
Yeah. We didn't – I think that – it wasn't assigned to us, I guess. Is that why we didn't talk about it, Jamie?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Right.

Clem McDonald – National Library of Medicine
And I know that in general there are some practices and some organizations that are terrified of data just flowing in from anywhere else with the idea that they're going to be malpractice responsible for dealing with any potential out – you know, things they should have done to deal with it. I mean, some kind of a handshake and understanding of what's to be done and what the response times will be and etcetera is going to at minimum be necessary, I think.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So what I'm getting from this is that there really are multiple issues. One is that the device messaging standards still have further to mature. Another is that unique device ID is needed as a part of the information to the provider. Another one is that the operational process as well as policies for incorporation of the external device data is needed and is not sufficiently mature.

Clem McDonald – National Library of Medicine
Yes.

John Halamka – Harvard Medical School
Works for me.

Jay Crowley – U.S. Food & Drug Administration
I agree.

Joyce Sensmeier – HIMMS
Mm-hmm.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. And actually, the – this is still presupposing that we're even going to have UDI requirements on retail or over the counter devices for – that generate measurements from the home.

Clem McDonald – National Library of Medicine
Well, we recommended that, right?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, we did, but –

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I don't – Jay can comment on that, but I – you know, wish I knew way that was going.

Jay Crowley – U.S. Food & Drug Administration
We are reviewing all the comments now, and we do appreciate the comments you all submitted, and hopefully we'll move in a reasonable direction here.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Great. Okay. Good. So now we did skip over an important item that was not assigned to us that I do want to go back to that has to do with adding a menu item for open notes, the progress notes. I mean, I think that –

Clem McDonald – National Library of Medicine
Where is that? I –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
This is – it's at the end of 204A.

John Halamka – Harvard Medical School
God, I had no idea that my study would be included in their questions.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

John Halamka – Harvard Medical School
God, I'm sorry.

[Laughter]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. So, you know –

Joyce Sensmeier – HIMMS
Great study, John. Great study. Good job.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Joyce Sensmeier – HIMMS
Fabulous.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. So how do we – how do we feel about this?

Clem McDonald – National Library of Medicine
Well, I can't – there's a lot of different parts on this table, and I don't think my eyes are finding what you're talking about.

John Halamka – Harvard Medical School
Clem, let me tell you what the study was, is that for two years we made physicians' clinic notes prospectively available to the patients after the clinicians writing them had effected to opt in to the sharing of what they wrote. So they knew that they would be communicating with the patient, and therefore, you know, they tended to avoid statements like, oh, the patient's fat and bald and ugly, or the patient is lying to me, or whatever. And it worked extraordinarily well, great doctor and patient satisfaction. I wouldn't suggest a core measure, but the idea of a menu set item that you optionally could include a clinic note in with an encounter summary, I mean, sounds okay.

Clem McDonald – National Library of Medicine
Well, it actually could be a big advantage, because there's other places where it asks for a specific patient written summary of what's going on, and we can't keep having extra things that aren't reused. That could be that, if they – if that's the goal, you know? You just write your note in a way that it's useful to the patient.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Joyce Sensmeier – HIMMS
Yeah.

Clem McDonald – National Library of Medicine
There was – how many doctors didn't participate?

John Halamka – Harvard Medical School
Well, we had 110 or something that participated out of our total of 600. But it was a study, so it was not meant to be inclusive of everyone. But it was so successful, then what happened, our board of directors and our medical executive committee made it mandatory for all doctors to participate.

Clem McDonald – National Library of Medicine
Oh, wow. So then what happened?

John Halamka – Harvard Medical School
And so that's being implemented now.

Clem McDonald – National Library of Medicine
Oh.

John Halamka – Harvard Medical School
And there's very little controversy, surprisingly. I mean, it just – we had no bad experiences. Geisinger also ran a very similar study and had very positive results.

Joyce Sensmeier – HIMMS
And, you know, the patient component of that is very compelling as well, because the high majority of the patients that participated wanted to be able to continue that type of ability.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Patients love it. Patients love it.

Joyce Sensmeier – HIMMS
And the – they found errors in their record and they were able to correct them, so –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And actually, very few – very few of the physicians wanted to discontinue it.

John Halamka – Harvard Medical School
Right. None of our physicians at the end of the study chose to discontinue their involvement.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah, I think it was slightly different at Geisinger. I think they had a few physicians who wanted to discontinue. But, you know, maybe three percent or something like that. Okay. So if it's okay, then, I think we can add a comment that we would agree that open provider progress notes could be a menu item.

John Halamka – Harvard Medical School
Good.

Joyce Sensmeier – HIMMS
Yes.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
All right. Good. Okay. The next part of 204B, then, that's assigned to us, is what information would providers consider most valuable to receive electronically from patients? And so I think the – this has to do with what are high priority health conditions. It's a pretty broad question. And the draft – the response that I've drafted says that there needs to be a definition of high priority health conditions, and I've pointed out potentially cancer, diabetes, and heart disease, but to define relevant standards, there needs to be some greater definition.

Clem McDonald – National Library of Medicine
Well –

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And I don't –

Clem McDonald – National Library of Medicine
Yeah, absolutely, but even more, I mean, what is – what's the picture here? What are they really thinking? Are you going to send daily pain scores? Are you going to – you're going to report your history once. Are you going to say which pills you're taking every day? I don't have – I can't guess at what they're really thinking, even when you pick the disease.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. I mean, I have to say frankly I don't understand why some of these questions are addressed to the standards group, per se, right? This seems much more in the – I mean, I think we could answer – we could give a policy answer, potentially, but this isn't really a standards question.

Clem McDonald – National Library of Medicine
Well, they may be – what this may be going after is the outcome sort of surveys of patient functional outcomes. But if they're going to be sent to them – and there's also that stuff you collect before you see the first visit that everyone would like to probably automate.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Well, another thing on this proposed menu item is it talks about semi-structured questionnaires, which we – in our previous comments, we said that that was a nonsensical idea, that either they should be structured or unstructured.

Clem McDonald – National Library of Medicine
Well, you can always have, you know, a place for other, which may be what they're thinking about with semi-structured. Well, my – again, the other side – so they've got to be more specific … people … what's good here, and if – I think it's probably the outcome variables that they collect in clinical trials now, you know, that reflects functional status. But that's a lot – and it might be desirable to get, but again, if it's just flown in every day, the expectations of results and all, we should be real sensitive to what – how practices are going to be able to spend the time doing that.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So what do we want to have as a response on this one? I mean, I've narrow – I've relatively narrowly said in the response that we – you know, we need to get more definitions in order to answer the question.

Clem McDonald – National Library of Medicine
Is this something that's likely to – I mean, with the – with the new kinds of care systems, that the market will do what it needs to get good care? We don't have to be specifying in standards? I guess they would need the capability for the standards to move it, but it's no different than any other data, really. It's just an observation, right?

John Halamka – Harvard Medical School
Yeah. I mean, at the moment, you know, we certainly think patient-generated data is going to be important for care management, but we have no idea how to do it. And we have no idea what to collect, what devices to put in their homes, what web pages to make available to them, how we're going to parse and filter the data, how we're going to alert/remind on the data, how we're going to curate the data. So, I mean, I think, you know, Jamie, as I said on some of these others, this is one of those multi-year standards committee chews on. I don't know that I have any maturity in the – either the standards or the policies around how to do this one.

Clem McDonald – National Library of Medicine
Well, the enabling requirement across a lot of the patient communication, except for the automated instrument stuff, would be an HL7 like structure for sending any kind of a panel or any kind of a questionnaire.

John Halamka – Harvard Medical School
Right. And so we – you know, Jamie, I think it was work that you did that looked at the use of LOINC and SNOMED, and asking questions and recording answers, and structured data capture of arbitrary nature, and that sort of thing.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yep.

John Halamka – Harvard Medical School
But that's – I don't know. I think that's not yet ready for Meaningful Use Stage 3.

Clem McDonald – National Library of Medicine
Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

Clem McDonald – National Library of Medicine
Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So how about if I just amend the current draft answer to add a statement that standards and policies are immature and should be on a multi-year work plan?

John Halamka – Harvard Medical School
Works for me.

Joyce Sensmeier – HIMMS
Yep.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. The next item that was assigned to us is SGRP205, which talks about providing clinical summaries for each patient visit, each office visit. And the question is what specific information should be included so that patients have a clear and concise access to information about their visit and what they can do next, and when to call the doctor, and so forth. And so the draft response says that in order to specify standards, the policy committee should clarify that the clinical summary content should include pertinent visit information, such as what was done, what the patient needs to do, tests that need to be done, and if – that – and dates by which they need to be done, and patient instructions related to goals and follow-up care. But I think we need to have that kind of enumeration of the – of pertinent visit information in order to do the standards work.

Clem McDonald – National Library of Medicine
Well, again, the thing that worries me is we've got this requirement, and we've got the concise plan requirement. There's like three different overlapping new documents that are described in this whole set of things. And again, I worry about everything collapsing if we don't – can't either automate it, or we can reuse one certain – and the idea of the patients getting the doctor's note, could we make that work for this? Or is this going to force us to do additional things?

John Halamka – Harvard Medical School
And so I like Jamie's response in that we can't answer that question, Clem, until you tell us what is it you're after here, you know? And that is if in fact what you want is a cogent summary of the care that was delivered during an episode, well, sharing the note probably will do that.

Clem McDonald – National Library of Medicine
Well, what – maybe we could add here comments that some thought should be given to how to use existing or other requirements to –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
How about if I say it this way? That we also need to ensure that this is not duplicative –

Clem McDonald – National Library of Medicine
Right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
– of care plan requirements, progress note requirements, etcetera?

Clem McDonald – National Library of Medicine
Yeah. Yeah. Good.

Jay Crowley – U.S. Food & Drug Administration
That's good.

John Halamka – Harvard Medical School
Yep.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Good. Let's see. The next item that was assigned to us is SGRP209, which is the capability for the EHR to query research enrollment systems to identify available clinical trials with a goal to facilitate identification of patients who might be eligible for a clinical trail – trial. The EHR would query clinical trial registries and identify relevant trials based on a patient's health condition, location, and other basic facts. The EHR would not be able to determine final eligibility for the trial, but it would be able to identify possibly relevant trial opportunities.

Now – so my draft response says that building a sophisticated algorithm could limit the quality of information by applying too many filters. In other words, it's not really workable today. And why not just mandate access to Clinicaltrials.gov from the EHR?

John Halamka – Harvard Medical School
All right.

Clem McDonald – National Library of Medicine
Well, I had a conversation with Deborah Zarin, who runs the Clinicaltrials.gov here, at Lister Hill.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Clem McDonald – National Library of Medicine
Because I saw this query, and I – and I was surprised to say, she said she doesn't think it – she thinks it hardly ever will be valuable, because the average patient doesn't have a problem that's in a clinical trial, or – or that the patient would think they'd be helped by it. You know, if you got a heart attack, are you going to seek a clinical trial? You're just going to go to the best doc in town. So I think your answer is a good one, Jamie.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, how about if we amend that based on what you just said, Clem, to say that this is not workable today, and applicable to very few patients?

Clem McDonald – National Library of Medicine
Well, but just saying they could get at it anyway, because they can do …

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Okay. Right. So we could just leave it the way it is?

Clem McDonald – National Library of Medicine
Well, maybe a caution that it may not be applicable to a lot of patients.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Clem McDonald – National Library of Medicine
I don't want to totally squash it, but I was surprised by – by her frank response.

John Halamka – Harvard Medical School
And so, you know, in terms of phrasing it in a positive fashion, low impact to offer an easy link to Clinicaltrials.gov. I wouldn't at this point in history think of automating it further than that.

Clem McDonald – National Library of Medicine
Yeah, yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm. So a low impact approach would allow access to Clinicaltrials.gov from the EHR.

John Halamka – Harvard Medical School
Right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Got that. Good. Next for us is SGRP302. This has to do with the reconciliation of contraindications. The core objective is that a provider or hospital who receives a patient from another setting of care who believes an encounter is relevant should perform medication reconciliation. And so the question here is about the feasibility to add additional fields for reconciliation, to add information about medication allergies, problems, and what the experience has been.

So the answer that I've drafted here is to say that more work needs to be done to define medication allergies and problems in relation to medication reconciliation, as well as vocabulary for contraindications and certain medication therapies, allergy severity ...

Clem McDonald – National Library of Medicine
Jamie, I read this a little bit that it wasn't in relationship to medication reconciliation. It's the same exact parallel process to the three other things. And I don't think they really are parallel. It's really very much like the discussion we had in one of the items in the early part of the –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah, I guess I read it differently, because looking at the measure, which is about med reconciliation and the certification criteria, it's talking about adopting standards for the nature of reactions to allergy – for allergies.

Clem McDonald – National Library of Medicine
Well, it might be. The first – yeah, there's three different sections, so – and it says they will perform reconciliations for medications, allergies, and problems. And I don't – I don't think that they understand the complexities of that space.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Clem McDonald – National Library of Medicine
I think what you – you know, what any – well, you'd assume that people get some new information, they'll see if it's needs to be added to the list. But the –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, what else should we say here?

Clem McDonald – National Library of Medicine
I would try to cool them on it. That it – you know, there's no examples of this being done. There's no idea what it's involved – what it might cost, what the value is, best I know about. Certainly there's been a lot of stuff with medication reconciliation, but there at least there's sort of a final attestable truth in some sense. You know, if it's not been dispensed by any pharmacy, maybe they're not taking it. But when you're talking about allergies, the patients often have the wrong idea about what they're allergic to. And problems is not a thing the patient usually concocts as – they don't – if we define the specification of a problem. So it seems like it's a mismatch of the content and the machinery.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So Clem, you're saying there are no examples of successful allergy and problem reconciliation that would …

[Crosstalk]

Clem McDonald – National Library of Medicine
Well, I don't want to … the universe, but I don't know a literature or a discussion space that people are even talking about what this means. It almost looks like some oversimplified translation. I think we should do it for this, we should do it for that. I mean, if they're saying is you'd like to have a tool that would let you pull up a list of problems or that – from somewhere else and see which ones you want to pick as a physician, you know, from inpatient to outpatient or from some other site, I could see that. But this reconciliation process, it isn't parallel for these. I mean, you know, if you took all the patients' allergies and stick them on the list, you may get worse – bad information.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So how about if we say that allergy and problem reconciliation processes are immature and should be further developed, and then –

Clem McDonald – National Library of Medicine
Trying to … yeah, and maybe – and get some idea of the value and what they mean by it in the value. Yeah. I – John, have you heard that expression applied to those others, the other two –

John Halamka – Harvard Medical School
Yeah, I mean, and so in general, medication reconciliation is ubiquitously done in all transitions of care at Beth Israel Deaconess and most Boston hospitals. No one does problem list reconciliation across institutions, because everyone records their problems in slightly different ways. But medications allergies are a mess because there's not a single bit of what I'll call detailed clinical model consistency across any EHR I've ever encountered with recording an allergy.

Clem McDonald – National Library of Medicine
Right. And you never know – I mean, there's not a place to go and validate, you know, show me your medication bottle. I mean, show me your allergy bottle. You know, so there isn't this opportunity to define the final truth.

John Halamka – Harvard Medical School
So Jamie, I think, you know, capturing the sentiment here is that it is absolutely the case that certainly medication allergy, detailed clinical modeling work needs to be done in order to even have any hope of comparability of medication allergies across entities and EHRs, and that certainly additional work would need to be done with regard to how we represent problems. Do problems have a start date or a stop date? Do problems have an active or an inactive indicator?

Clem McDonald – National Library of Medicine
Oh, and you get – so you've got one guy has a problem with chest pain, and another one calls it ischemic heart disease, and there's text attached to them, and it's just not something – it's a big, difficult thing even to manage problem lists on your own record. And we're trying to – if there's – so I think the clarification is are they really saying you'd like to be able to review information about these things from other sites and pull them in if you wanted? Or are they saying they really –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, they're talking about reconciliation the way you do a med reconciliation, and I think that's, you know, part of the problem.

Clem McDonald – National Library of Medicine
Right. I don't think there is such a thing. I don't – I don't think – it's –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So let me try this – try this revised statement on for size for the group here. This should be deferred. Allergy and problem reconciliation is immature and should be further developed with a value case.

Clem McDonald – National Library of Medicine
Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
More work needs to be done to define medication allergies and problems for this purpose, as well as vocabulary for contraindications, allergy severity, etcetera.

Clem McDonald – National Library of Medicine
Yeah.

John Halamka – Harvard Medical School
I like it.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Good. So that one's done. Now SGRP303 is one where it was assigned to us as the secondary commenter. I did not draft a comment. The question is for transitions of care and providing summary records, what's a – an appropriate increase in the threshold value based on evidence and experience? I don't know the answer to that.

Clem McDonald – National Library of Medicine
Well, I – you know, I think certainly the idea of getting transitions – if the transitions are defined correct – well, that's a good idea.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, how do you define a transition – I mean, this is a problem that we have. How do you define a transition when you share a single record?

Clem McDonald – National Library of Medicine
Well, that's the other problem, is how big a deal is it before you declare it a transition? And this stuff only works if it's a big deal.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, I mean, you know, but – do you do any – should there be any duplicative transmission of data if – in an accountable care organization, if you're sharing a single patient-centered record? If that's, you know, actually the objective, transmission of data in a trans – in a transition is – is actually contraindicated.

John Halamka – Harvard Medical School
Right. So Jamie, to your point, my Meaningful Use Stage 2 team said, John, we have no idea how to define the denominator for this particular measure, because what is the definition of a transition of care between two doctors who work from the same organization? You know? We – or even if it's two different organizations, but they each have access ubiquitously to each other's data through – well, we've done a sort of interesting EHR access with a single context sensitive click. So yeah –

Clem McDonald – National Library of Medicine
Well, I think – I think you could make the argument, if you go to the most extreme cases, so a hospital discharge, there's going to be a transition of care, typically, and most people won't disagree with that. And there is a special effort made to do something, you know, in terms of the summary and the goals and all. When you get down to going from one dermatologist to another, it gets a little bit fuzzier, whether they're out in different practices or not. But if we started there, you know, I think it's a discharge summary, probably, right? That defines it? Here the problem is we're creating extra documents or extra work.

John Halamka – Harvard Medical School
Right? So I have the same problem you do, Jamie, which is, okay, if it's ten percent for electronic transmission today and we say, oh, you know, we got to move it to thirty percent, because that's really what happens a lot between meaningful use one stage and the next, I mean, maybe that's okay, but it really just depends on how you craft the numerators and denominators as to what a transition means.

Clem McDonald – National Library of Medicine
Is that defined anywhere? Is it accessible, how it's defined?

John Halamka – Harvard Medical School
I haven't seen it.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I think that is a legal interpretation question that may be done differently, either from –

Clem McDonald – National Library of Medicine
Well, I thought I read that it was pretty – it was – the last round, I thought it was like big deals, but I may not have read it carefully. I know that discharge from emergency room and from hospitals were both transitions of care, and there won't be that – that won't be killing, because there aren't millions – well, there are millions, but there won't be so many that that would be killing. And then the question is are we defining new things that are duplicating or semi-duplicating existing things? But I don't – I am not in either of your businesses, so I don't know what the challenges are. You guys should make the call on this.

John Halamka – Harvard Medical School
Some – Jamie, do you think it'd be worthwhile to actually say, we will be happy to make a recommendation as to what the threshold should be pending the further clarification of the numerator and denominator details, such as classifying what a transition is?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. I like that. So I think that – okay, so the threshold should depend on clarification of numerator and denominator.

John Halamka – Harvard Medical School
Right. How does one classify a transition?

Clem McDonald – National Library of Medicine
Well, you might go further and say that with – we accept that a hospital discharge or an emergency room discharge is a transition, but is transfer of care from one provider to another when you've got the same record a transition?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, you know, in fact, I would say that we need to ensure – add that – so the threshold depends on classification of transitions, but we also need to ensure that the definition of transitions allows for shared patient records, not only fragmented physician records, to be used.

John Halamka – Harvard Medical School
Right.

Clem McDonald – National Library of Medicine
But there is a – I mean, the shared patient record is a great help. You know, I've lived with one, too. But it's not quite the same, like, you know, when they do the night transits, it's not quite the same as someone giving us a little brief summary of what's going on with the patient. It isn't – you don't have to scour the record and draw inferences. I'm not suggesting more work, but there is a difference in saying –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So now you're talking about, you know, sort of case management, right? And –

Clem McDonald – National Library of Medicine
Well, I didn't mean it that way, but, you know, say in an inpatient setting, when the one team takes over, they go around with the other team and they give them usually like two-line summaries of the patient. That's quite – and I think there's something analogous, if you discharge a patient, you don't just say, here's the whole record. You know, you –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So – right. But – so we do that in case management notes that are shared among – so again, shared across the entire care team, all specialties, primary care, and inpatient and specialties all share the identical case notes, share the identical patient record and information. So it's – you know, it's literally one integrated patient record. So why would you want to then require burdensome and duplicative transmission of data, you know?

[Crosstalk]

John Halamka – Harvard Medical School
Yeah.

Clem McDonald – National Library of Medicine
You're not –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
You've got everything in one place.

Clem McDonald – National Library of Medicine
Yeah. You're not going to get me on the side of burdensome. I'll stay out of it. You guys know it more than I do. So why don't you just go to 12 percent? You know?

John Halamka – Harvard Medical School
Why don't we go to eight percent? Yeah. I mean, I think that – I like what's been said, but, you know, I – some – you know, some additional thoughts, in a sense, where there's a shared record, you know, there's been some discussion at least that you hurt – you hurt things by essentially creating a summary and then people look at the summary, when in fact what you could have done is if there was any problem, go directly to the electronic record and see current data rather than the summary – well, a summary that's created, you know, on demand as opposed to a summary that you create and transmit to somebody or give to somebody, and then they – you know, they're fixed at that point in time rather than being current with the data that's actually –

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Right. Exactly. Thank you. Because – you know, so that's the – you know, so why would you take a snapshot when you've got the whole picture, right?

John Halamka – Harvard Medical School
Exactly. I mean, you still might have the need to do a summary so that they can see what's pertinent, if you will, but that – you know, but that's the whole idea, you know. Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, but the summary is useful for – you know, for the patient download. It's useful for discharge or for an after visit summary or something like that. But for a – you know, a transition between different parts of the care team, such as a night shift or a weekend shift for inpatients, or, you know, somebody goes to a different department for a procedure within the hospital, you know, in all of those cases, if you've got the sharing, then I think that the summary is actually less – it's negatively useful.

John Halamka – Harvard Medical School
Right.

Clem McDonald – National Library of Medicine
Well, I think if –

John Halamka – Harvard Medical School
Detrimental.

Clem McDonald – National Library of Medicine
– you go to this next page of your – of the document, I think – what it's defining transitions is in terms of changes of setting, if I'm reading this correctly. That's not as onerous. It says transitions or – well, maybe it doesn't. This is under the measure.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

Clem McDonald – National Library of Medicine
That it refers the patient to another setting of care, including home. Oops. Never mind. It says or provider.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
Yeah. What we ought to argue, that there should be a – there should be some clarification of definition, and maybe – what I would argue for, just making it setting, because it's more crystal clear.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

Clem McDonald – National Library of Medicine
It's actually – it's actually now referrals, too. Holy – I think I'd do that for any referral. This is overkill.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, what do we want to say about this, then?

Clem McDonald – National Library of Medicine
I think there – maybe there should be some rationalization of the transitions for which this larger effort is required.

John Halamka – Harvard Medical School
Well, and that was what I was getting at, is if we simply state is at need clarification on the numerators and denominators for what constitutes a transition.

Clem McDonald – National Library of Medicine
Well, I'd go further and argue for them not making up anything they want.

John Halamka – Harvard Medical School
Right. Well, that's why we want a crisp definition, because then once we have it, then we can determine, you know, maybe this one's easy to achieve, maybe it's hard to achieve. Depends on how you classify what constitutes a transition.

Clem McDonald – National Library of Medicine
Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So how about this? Transitions for which this is appropriate should be rationalized, and the threshold should depend on the classification and definition –

Clem McDonald – National Library of Medicine
Yeah.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
– of transitions.

Clem McDonald – National Library of Medicine
Right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
And we need to ensure that the definition allows for shared patient records, and not just the fragmented record scenario.

Clem McDonald – National Library of Medicine
Good.

Jay Crowley – U.S. Food & Drug Administration
I like it.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Hang on just a sec here.

Clem McDonald – National Library of Medicine
Now there's two little bullets at the very bottom, one called consultation request, the other transfer of care. Is that just further definitions, or is – it just looks like a ramble, at the bottom of the third column – the second column. Just –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, it says that the following are expected to be – to complete HL7 balloting for inclusion in the consolidated CDA, the consultation request and transfer of care.

Clem McDonald – National Library of Medicine
Well, these things we should pay attention to – I should personally anyway – but there could be tons of data collection required that may or may not be totally sensible.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm. Well, I think, you know, if we were saying that transitions for which it's appropriate should be – need to be rationalized, does that capture the sentiment well enough?

Clem McDonald – National Library of Medicine
Yeah, I think it – I think it does.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So then that's it for 303. On to 304. So 304 says that providers who transition their patients to another site of care or refer them to another provider should share care planning and care plan tools. So the draft response is that goals for the documents should be more specifically defined, that, again, you know, as in the previous one, to encourage team-based care, unnecessarily and burdensome data transmission should be avoided, and shared document solutions should be enabled and developed.

Clem McDonald – National Library of Medicine
But this looks like just one more set of things that's a lot like the other ones –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yep.

Clem McDonald – National Library of Medicine
– that people are going to have to do under regulation.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yep. That's right. This is – this is essentially a similar thing, but it's for care plans as opposed to summary documents.

John Halamka – Harvard Medical School
And so again, in our multi-year plan, I had highlighted the idea that there are additional content standards needed for such things as care plans, but yeah, I certainly concur with the comments that you've made.

Clem McDonald – National Library of Medicine
Well, I think it's worse than that. I mean, this isn't just – at least, as I understand care plans, it specifically says medical diagnosis in stages, that stages is a new critter. Medical diagnoses are going to be the problem list, which is also required somewhere else, functional status, including ADLs. You know, that's a five, ten-minute data collection thing, depending on – I mean, it can be. Relevant social and financial information. This is a whole bunch of new stuff, and there's no clarification of how it relates to the other things that are already required or proposed.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, how about this? How about if that in response to that, Clem, at the end – so the first sentence of the draft says that goals should be more specifically defined. How about if we say goals should be more specifically defined, and additional data collection requirements should be carefully weighed against caregiver burdens?

Clem McDonald – National Library of Medicine
Yeah. Justified.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Justified.

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Is that okay?

Clem McDonald – National Library of Medicine
Yeah. And then you might also say this seems duplicative of some of the other required documents that are – have been specified in this or in other – or previous – MU2. I mean, if you look at what's in CDA, it's got some of this already. I mean, the consol – you know, the regular, consolidated CDA, or the minimum stuff in the – in the MU2. And I don't have any idea what we really mean about the patient's long term goals. And how does that interact with the other goals? And a patient's going to say they want to live a long time, and I'm for it. A lot of this stuff is kind of loosey-goosey.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I'm just taking a couple of notes here. So let me read this back. So the revised draft comment says, goals for the clinical document should be more specifically defined. Additional data collection required by caregivers should be justified, and existing data should be reused to the extent possible. And then – and then basically it continues to say, to encourage team-based care, unnecessary transmission should be avoided and shared record solutions – shared document solutions should be developed.

Clem McDonald – National Library of Medicine
Okay.

John Halamka – Harvard Medical School
Good.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
All right? Okay. Good.

Clem McDonald – National Library of Medicine
What I'd rather say is: Why don't we just drop this one?

[Laughter]

John Halamka – Harvard Medical School
So of course, the policy committee has come up with these things, and we are basically given the option of saying core, menu, further work necessary.

Clem McDonald – National Library of Medicine
Well, I mean, I think they're responding to just – they're open to all suggestions, and I'm assuming they just take an awful lot of stuff and accept it without, you know, severe kind of constraining at this stage.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Okay. Now there is another part of this, which – that was assigned to us, where the question is: What are the most essential data elements for ensuring safe, effective care transitions and ongoing care management? And –

Clem McDonald – National Library of Medicine
It's Clem; is that in a different part with different letter series?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
It's in this – it's a – no, it's just – it's a – let me see.

Clem McDonald – National Library of Medicine
GRP – they're not … GRPs?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Scroll down a little bit. It's in just another part of 304.

Clem McDonald – National Library of Medicine
Oh, okay.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
It's an additional question on 304, is what are the most essential data elements. And I'm not sure how to answer that.

Clem McDonald – National Library of Medicine
Well, the thing that physicians most often can't get is diagnostic study and laboratory results, and clarity on what drugs they're discharged on, or they're supposed to be on. I mean, those are sort of the life and death things. If you don't – if you're – and they're not things – you know, a lot of things you can get from the patient that's history, but they don't usually know the values of their tests or the real results of their special diagnostic studies. And it – if you're talking about the critical things for taking care of patients, I don't – if you send me someone and I don't know that, I either waste a lot of money or I could do harm.

Joyce Sensmeier – HIMMS
Well, it also – this is Joyce – in terms of essential data elements, I think that there's going to be a nursing perspective as well. And I think it would be important to get that perspective to weigh in on this, if we're going to go down that path.

Clem McDonald – National Library of Medicine
Well, could you – do you have some additional things we should talk to, speak to?

Joyce Sensmeier – HIMMS
Well, there is – I'm involved with Bonnie Wester and a couple of other key nursing leaders in coming up with some of that, but it's work that's in progress, so it's not going to –

Clem McDonald – National Library of Medicine
Okay. But the thing – if one, you know, keeps in mind that the patient's a pretty darned good automatic, you know, voice understanding system that can give you a lot of information, and think about what – the things they don't know, or won't – usually won't know, those are the things that kill you, I mean, really are hard. I don't know – I mean, so it'd be nice to see their list.

John Halamka – Harvard Medical School
So Jamie, here's an example. We have a project called Passport to Trust, where the doctor and the patient actually create a shared care plan, identifying the patient's goals, expectations, and preferences, and that is – it's a working document, and it evolves over time. But, you know, if you're diagnosed with prostate cancer and you say, you know, I'm going to die from the – not from this, but with this, I actually don't want surgery. You know? Fine. Great. Here's your expected outcome. Here's your expected treatment. You know, good. We'll document that.

So in effect, it could be a CDA representation of a shared care plan. But this is all pretty embryonic work, and, you know, I – as I said, I think we have this multi-year work plan items, including how do we deal with care team care plan representation. And, you know, this could be part of that.

Clem McDonald – National Library of Medicine
Well, if one looks at the – in the introductory phrase, what are the most essential elements for safe, effective care transitions, I still go back to what I said, assuming the patient can talk and think, because they can tell – they'll – you know, they can still report all that other information and their perspectives and what they want. Now if the patients can't – you know, is unconscious, then you got a whole other set of things you need.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I'm still not clear how we want to answer this.

John Halamka – Harvard Medical School
Right. And so I – this is obviously a non-answer, but it would seem to me that if what we said was it is clear that the data that patients and doctors will develop in terms of a shared care plan recording preferences and expectations is desirable and a work in progress, and that, you know, I don't know that you could really include it in a Meaningful Use Stage 3 core menu set requirement at this time. That, you know, additional work is necessary to identify what would be included in a shared care plan reference care team expectations document. Because other than that, I'm going to say the essential data elements are the problem list, the medication list, the allergy list, and the most current labs.

Clem McDonald – National Library of Medicine
Yeah. Yeah. Well, I guess the one I'd add to that, having you guys talked a little bit, is the advanced directive, which these things are going to encourage getting one on everybody.

John Halamka – Harvard Medical School
So, I mean, the problem I guess I have, Jamie, is that I think that today, again, thinking of implementation reality, it is essential to send a problem list, a medication list, an allergy list, and the current labs. And in the future, it would be highly desirable to send the patient's care plan, expectations, and preferences. However, I don't think we have such standards or even definitions of what those things are mature enough to include them at this time.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. So I like that.

Joyce Sensmeier – HIMMS
Yeah.

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Joyce, were you going to say something?

Joyce Sensmeier – HIMMS
Yeah. I'm sorry. I just wanted to make sure we make that interprofessional, so that we don't lose the nursing perspective on that as a part of the care team.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. I – so I think we've got that one. And actually, that is the – I think our last assigned SGRP. Now – so there's a whole – there are many other questions here that were not assigned to us, but if we skip down to the end of the document, where there are these additional questions that were assigned to our team, I haven't drafted answers to any of those yet, where it's – MU01 is the – is the starting point on that. And I – the question is, currently providers have to meet all meaningful use criteria to receive incentives. Is there flexibility in achieving a close percentage of the objectives, but not quite achieving all of them, and what is the downside of providing this flexibility? How will it impact providers who are achieving all of the criteria, and if there is additional flexibility of this type, what are the ways this could be constructed so it's not harmful to the goals of the program?

Clem McDonald – National Library of Medicine
Well, I think flexibility is always good.

John Halamka – Harvard Medical School
It is, but the problem is it becomes unmeasurable.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

John Halamka – Harvard Medical School
I mean, I really – today, you have menu set and core, and you have flexibility as to what you choose in the menu set. That's sort of the notion of it's not totally pass/fail. You've got flexibility. But I worry if you say, well, if you can get 80 percent of the core, then you can get 80 percent of the stim – I mean, it gets to be unmeasurable.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, you know, I think one way to achieve greater flexibility is just to make more things menu and fewer core.

John Halamka – Harvard Medical School
Right. Sure. So you could say that.

Joyce Sensmeier – HIMMS
Yeah. Otherwise, you get a variation on the theme that's exactly not measurable.

Clem McDonald – National Library of Medicine
Well, I think the other way to do it is to say, you know, if – what we now have is threshold effect. If you don't get to whatever that percentage is on – you know, you're at three out of four, but you're actually over on – you know, it's – I think – I thought they're getting at that you could – if you did really much better on some, you could get some credit in tradeoff against the others. Thresholds aren't necessarily the best way to get – to get stable outcomes. So we have these absolute thresholds. So if the thing was that you could do better on one, as long as you're above, you know, 80 percentile of people responding on those, you could make up the difference on doing over the score for others.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. That gets to a measurability problem, I think. I mean, you know, personally I prefer the approach of saying if you want to achieve more flexibility, just make more things – put more of the core items in the menu set. And otherwise leave it alone.

Clem McDonald – National Library of Medicine
That sounds like the consensus then, huh?

Joyce Sensmeier – HIMMS
Yeah. They'd be adding a lot of complexity the other way.

John Halamka – Harvard Medical School
Yep.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Okay. The next question assigned to us is what is the best balance between ease of clinical documentation and ease of practice management efficiency?

John Halamka – Harvard Medical School
I'm not even sure what that means.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, I'm – you know, I really thought practice management systems were not in scope for EHR, frankly.

Clem McDonald – National Library of Medicine
What was the number there, Jamie?

John Halamka – Harvard Medical School
It's MO02 – MU02.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
MU02.

John Halamka – Harvard Medical School
So maybe what they're getting at is as follows: that a practice management system, aka, a billing system, requires selected documentation elements in order to justify a code, which will give you a bill that is perceived as either upcoding or downcoding, and in fact, if ICD10 requires you to document such things as struck by turtle in squash court, and you have to determine whether it's the snapping or non-snapping variety, there could be very burdensome documentation.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, and again, you know, frankly, when you get to models of accountable care and move up the chain to capitation, that becomes irrelevant, right? I mean, as a – as a billing question. It may be perfectly relevant as a clinical question. You may want to document it that way. But I think the whole – personally, I think the whole idea of practice management efficiency is not in scope for the EHR.

Clem McDonald – National Library of Medicine
Well, we're talking about MU02?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yes.

Clem McDonald – National Library of Medicine
Well, it says use them to achieve improvements in hypertension control. Is that what you're tall talking about?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
No. It's after IEWG –

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. After IEWG103, there's a statement, it says, in addition to the questions above, HITPC would also appreciate comment on the following questions. And then there's ID number MU01 and MU02.

Clem McDonald – National Library of Medicine
Yeah, but what I'm reading in mine in green font is use EHR technology features, registries, to achieve improvements in hypertension control.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Hmm. I don't have that.

Jay Crowley – U.S. Food & Drug Administration
Yeah. I don't have that.

Clem McDonald – National Library of Medicine
Well, okay. I don't know what's going on.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
It's above the quality measures section?

Clem McDonald – National Library of Medicine
Well, it's HITPC Stage 3 Request for Comment. This is not your document, but the document that came from higher up.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Oh, okay.

John Halamka – Harvard Medical School
So Jamie, let me give you an example. Computer assisted coding conceivably could ease the balance between a clinical documentation, clinical application, and the necessary ICD-10 coding put into a practice management system. I mean, so again, this is a weird question. It doesn't seem like it's relevant for meaningful use. But sure, there are technologies that are being created today, NLP-based technologies, that will help reduce the burden. I wrote a blog on it yesterday. But –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah, I – so I don't disagree at all, and I think that, you know, the model of using – eventually using NLP to do coding off of text, in addition to automated translation from clinical documentation in SNOMED into whatever is needed for administrative purposes, you know, I mean, I think that's all fine. I don't understand what that's doing in meaningful use.

John Halamka – Harvard Medical School
Exactly. I mean, so we could just make the comment, there are evolving NLP technologies and computer assisted coding that will help reduce the burden. Thanks for asking. It's not relevant to meaningful use.

[Laughter]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. I'm just making a couple of notes here. Okay. The next item, let's see, assigned to us, where we're one of the secondary commenters, MU03, to improve the safety of EHRs, should there be a meaningful use requirement for providers to conduct a health IT safety risk assessment? Are there models or standards we should look to for guidance? Well, you know, we just saw the ONC framework released a couple of days ago, right?

John Halamka – Harvard Medical School
Right. And so my answer to that is, is that this is an evolving, multi-year body of work. There are going to be usability standards that we can look at from NIST over time. There should be such things as defect reporting to PSOs, all the things that were outlined in that particular report. At the moment, I think it is quite premature to suggest that there could be a reasonable health IT risk assessment done at the level of maturity of our understanding of the problem today.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
But – I agree completely, and I – you know, I'm – I really – I think the idea that there should be an additional reporting burden to certification bodies, for example, seems premature at best.

John Halamka – Harvard Medical School
Agreed.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So how about if we just say, this is an evolving area where we need a multi-year work plan item for future work?

John Halamka – Harvard Medical School
Agreed.

Clem McDonald – National Library of Medicine
You're always so gentle.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well –

Clem McDonald – National Library of Medicine
You may have learned.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I mean, I think you can read between the lines on an answer like that, that says, what are you guys smoking?

[Laughter]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. The next item where we are a secondary commenter is MU05, which I'm just reading here, so hang on a second.

Clem McDonald – National Library of Medicine
None of your MU0s match up with what I've got, so I'm trying to find – you're not showing that on your screen, are you?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
It is showing on – yeah, actually, if we could scroll to the left, then – right. So now it's showing on the screen.

Clem McDonald – National Library of Medicine
Could you make the font bigger, or is that my job? Never mind. I made it bigger.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

John Halamka – Harvard Medical School
So MU05, Jamie, basically refers to the smart platform that is part of the SHARP grant, the notion that instead of using transaction standards or summary standards, we would have APIs that would enable an ecosystem of modular apps to call directly into the data structures of an EHR. And so in effect we go from interfaced to integrated.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

John Halamka – Harvard Medical School
And, you know, I think APIs are a fascinating thing to think through, and we have a SHARP grant that's working on that, and $15 million of hard-earned research information will certainly be coming back to the standards committee soon.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Well, and this is – this is the whole area of the model-driven tools development, right? And Rob Kolodner's new life's work. But it's immature, right?

John Halamka – Harvard Medical School
Correct.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
How about if we just say it's currently immature and further development is needed?

John Halamka – Harvard Medical School
Sure.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Okay. The final item here, MU06, what can be included in EHR technology to give providers evidence that a capability was in use during the EHR reporting period for measures that are not percentage-based? Are there objectives and measures that should be prioritized to assist providers in showing that the capability was enabled during the reporting period?

John Halamka – Harvard Medical School
So let me give you an example of this one. One of my hospitals was audited for Meaningful Use Stage 1, and they said, well, you've provided letters from the manufacturers that the particular certified version was installed, and you provided an attestation, and you provided data, but how do we know that for three weeks in the middle of the reporting period you didn't de-install the application and not use it?

[Laughter]

John Halamka – Harvard Medical School
You know, why don't we do this? We'll take –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
That just doesn't sound like a core EHR function to me.

John Halamka – Harvard Medical School
You know what we can do? We'll take a photograph of each particular reporting day showing a block on the wall, a calendar page, and a doctor entering an order. How about that? You know, I mean, so – you know, silliness aside, maybe an EHR has what I'll call an audit log that identifies if a particular feature has been disabled.

Clem McDonald – National Library of Medicine
Can't we just say it's a bad idea?

[Laughter]

John Halamka – Harvard Medical School
Well, I mean, there's got to be an element here of trust that if you implement a certified system and you have a letter that is notarized from your vendor and you have reports that demonstrate that the function was at the end of a reporting period, you know, filled with data of numerators and denominators or yes/no, you know, there's got to be some element of trust that there was actual use of it during the entire reporting period, unless you want to mandate an audit trail of features being turned off and on.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah.

John Halamka – Harvard Medical School
Seems very premature.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
I agree.

Clem McDonald – National Library of Medicine
Hey, John, could – what's the document title on your whole document? Because I'm trying to reconcile –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
The document title is HITPC underscore Stage 3, underscore RFC underscore final underscore HITSC.

Clem McDonald – National Library of Medicine
That's the name of the – the file name?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Underscore COWG. Yeah. So HITPC Stage 3 RFC final HITSC COWG.

Clem McDonald – National Library of Medicine
Okay. I'll probably do this after the fact, after we get off.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

Clem McDonald – National Library of Medicine
Everything else seemed to line up all right.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Just a quick note – making a quick note here. Okay. Now there are a couple of the quality measure items where we are asked as one of a list of – or as a secondary commenter, we're asked to comment, such as how can the policy committee capture input from a wider variety of providers, patients, organizations, and societies? What other channels for input should we consider? What I'm going to suggest is that we just handle that, those general items, within the standard committee meeting. And so I think we're actually done with our input for this document.

John Halamka – Harvard Medical School
Works for me. And as I said, Jamie, during the course of all our discussion, I did take notes, and I'm going to forward you a draft that I just sent to MacKenzie and to some others of what I think are the multi-year work plan items.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. And I've also – I've been taking notes on my own copy of this. I will clean those up and send them back out to the group as a – as a revised draft document.

John Halamka – Harvard Medical School
Great.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
On this – on this spreadsheet.

Joyce Sensmeier – HIMMS
That's good.

Clem McDonald – National Library of Medicine
Jamie, if you have that document handy, could you also email it to me?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yes, I will. Well, I'll just include you on the next distribution, if that's okay.

Clem McDonald – National Library of Medicine
Will that be soon?

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. Yeah.

Clem McDonald – National Library of Medicine
Because I'm developing comments for the – just general comments.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. No. I mean, I'm going to do that immediately when we close this call.

Clem McDonald – National Library of Medicine
Thank you.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
So I – is there anything else that we want to bring up that we want to say for this particular piece of work?

Clem McDonald – National Library of Medicine
Well, I come back to the fact that – you know, I brought – I'm putting my oar in the water a couple of places, that we just seem to be going so trickily slow on really getting electronic data that exists electronically almost everywhere into this physician's office computer, from where it's produced. And, you know, we made a couple of whacks at it, but man, you know, it's not a very fun thing if you just get part of the data. I don't know if we could encourage them to be more aggressive about, you know, picking up the other things that are sort of low-hanging, other – you know, spirometries, EKGs. We talked about them. More lab results than the very timid way they're doing with it. Maybe stay away from cultures and suscept – or susceptibilities, which get tricky. But, you know, it's –

Joyce Sensmeier – HIMMS
Question. How is e-prescribing going? Is there anything more to say about that?

Clem McDonald – National Library of Medicine
I think it's a done deal.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yeah. I thought that was pretty much done, except for the controlled substances, which a lot of people aren't doing yet.

Joyce Sensmeier – HIMMS
I don't know many doctors right now that are sending e-prescriptions, but that may be –

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Oh –

John Halamka – Harvard Medical School
Yeah. And so for example, in Massachusetts, we're 96 percent of all prescriptions are electronic at this point.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
That's not happening in Northern Virginia and Maryland, I'll tell you that.

John Halamka – Harvard Medical School
I'm curious, Jamie. There is one other standards gap on e-prescribing that Jim Walker talked about, and that is the cancel transaction for hospital e-prescribing of discharge medications.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Mm-hmm.

John Halamka – Harvard Medical School
And that is, there is some NCPDP 10.6 support for it. I just don't believe that any pharmacy has implemented it.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay.

John Halamka – Harvard Medical School
And I put that in the work plan that I just sent you.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Great. Okay. Then I think we're done with our comment development, unless there's something else we want to add to this particular spreadsheet. I really want to thank everybody for being on the call and participating here today.

Joyce Sensmeier – HIMMS
Thank you, Jamie, for your leadership.

John Halamka – Harvard Medical School
Yes, absolutely. Thanks, Jamie, for doing all the comments, the heavy lifting. And I think we came out of this with a very salient set of comments that certainly align with my operational experience, and they're balanced. I mean, you were very good about saying, well, not no, but not now.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Right. Right. It's a nice objective for the long term, you know.

John Halamka – Harvard Medical School
Great. Well, have a wonderful afternoon, and I guess I will see you all next week at the standards committee.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yes.

Joyce Sensmeier – HIMMS
Great.

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Now do we do – take public comments?

MacKenzie Robertson – Office of the National Coordinator
Yes. So before we go, let's just open the line for public comment, please.

Caitlin Collins – Altarum Institute
If you are the phone and would like to make a public comment, please press star 1 at this time. If you were listening via your computer speakers, you may dial 1-877-705-2976 and press star 1 to be placed in the comment queue.

Farrah Darbouze – Office of the National Coordinator
And this is Farrah. While we're waiting for public comment, Jamie, can you please make sure to send me a copy of the compiled …

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yes. Yes. Absolutely.

Farrah Darbouze – Office of the National Coordinator
– so I can make sure to get …?

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Yes. Absolutely. And I apologize. I may have not sent you something, but absolutely. So I will ry to turn this around as quickly as possible after the call.

Farrah Darbouze – Office of the National Coordinator
Thank you very much.

Caitlin Collins – Altarum Institute
We do have a comment from Carol Bickford.

Carol Bickford – American Nurses Association
This is Carol Bickford from the American Nurses Association. Thank you very much for your very informative conversation. I appreciate all the hard work you've done in assessing all the questions that you've been assigned, and even those that you weren't assigned. I would encourage you to make sure that any of your responses are provider neutral, that they are eligible providers or hospitals, not physicians. That makes it more inclusive across the spectrum.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Great. Thank you. And let me just say, we – you know, we did include the – I think in a couple of places the need to include nursing input and interprofessional information sharing, so – but yes, we'll be careful about that. Thank you.

MacKenzie Robertson – Office of the National Coordinator
Are there any other public comments?

Caitlin Collins – Altarum Institute
We have no more comments at this time.

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Okay. Thanks, everybody.

John Halamka – Harvard Medical School
Yes. Thank you. Talk to you later.

[Crosstalk]

James Ferguson – Kaiser Permanente – Vice President, Health IT Strategy & Policy
Talk to you later. Bye bye.